MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9016 **CERTIFICATE OF DEATH** 09001

1. **PLACE OF DEATH**
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 18yrs. 10mo. 7days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3017 Barclay 3V01-4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ANGELO — Middle (NMI) — Last BIANCERINI

4. **DATE OF DEATH**: Month August — Day 1 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-11-89

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State, or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): Yes WW-I

16. SOCIAL SECURITY NO.: Not available

17. **INFORMANT** Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Leukemic infiltration of kidneys — unknown
DUE TO
(c) Chronic Lymphocytic leukemia — years

204.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. p.m. — Month, Dey, Yeer: VA 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that ~~(I the hospital)~~ attended the deceased from September 25 1942 to August 1, 1961 ~~saw the deceased alive on~~ and that death occured at 6:35 a.m. from the causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney — M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8-1-61

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY
22d. ADDRESS: Asst. Clinical Pathologist, V.A. Hospital, Perry Point, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 803-61
23c. NAME OF CEMETERY OR CREMATORY: Baltimore Natl. Cem.
23d. LOCATION (City, town or county) (State): Balto. Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John C. Miller, 2433 E. Oliver St. Baltimore, Md.
25a. REC'D BY REGISTRAR DATE: AUG 7 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9011 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09002

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Conowingo
c. LENGTH OF STAY IN 1b: 4 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3903 Frankford Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3V01-4

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Clarence	Robert	Blackwell	8	15	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W		8-7-1909	52 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bus driver	Baltimore Transit Co.	Tenn	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Charles Blackwell	Sallie Butler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Mrs. James C. Blackwell	Baltimore, Md. 3903 Frankford Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R.C. Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-15-61

EXAMINER'S NAME (Type): R.C. Dodson
Address (Street, City, Town, or County): Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country)	(State)
BURIAL	8/19/61	MORELAND Mem.	BALTIMORE	Md.

23. FUNERAL DIRECTOR	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
L.J. Ruck	5305 HARFORD Rd.	DATE AUG 18 '61	Arthur J. K...

IF DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
IF FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9012

CERTIFICATE OF DEATH

Reg. Dist. No. 03003

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 3 Hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chesapeake City
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle MADLYN Last CALLAHAN

4. DATE OF DEATH: Month August Day 27, Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 2, 1888

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most af warking life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Hogate

14. MOTHER'S MAIDEN NAME: Lillian Arrants

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

INFORMANT Address: Richard M. Callahan Ches. City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line far (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 4 Days
420 - 1
DUE TO
Conditians, if ony, which gave rise to immediate couse (o), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 5, 19 36, to August 27, 19 61 that I last saw the deceased alive an Aug 27, 19 61 and that death accurred at 3:54 M. from the causes and an the date stated abave.

ACTUAL SIGNATURE: Henry V Davis M.D.
ADDRESS (Street, city ar tawn, state): Chesapeake City Md
DATE SIGNED: 8/28/61
PHYSICIAN'S NAME (Type): HENRY V. DAVIS MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/30/61
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
22d. LOCATION (City, tawn, or county) (State): Near Chesapeake City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: PIPPIN FUNERAL HOME Elkton, Md.

24a. REC'D BY REGISTRAR DATE: AUG 31 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, ar removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9013

CERTIFICATE OF DEATH

Reg. Dist. No. 09005

1. PLACE OF DEATH
o. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Elkton
c. LENGTH OF STAY IN 1b: 18 Yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Elkton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LE ROY — Middle: GLENN — Last: COLE

4. DATE OF DEATH: Month: August — Day: 15 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 31, 1886

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward O. Cole

14. MOTHER'S MAIDEN NAME: Ida Tennant

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-20-9564

INFORMANT: Mrs. Iva C. Cole — Address: Nr. Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 min.
DUE TO
(b): Arteriosclerotic hypertensive
Conditions, if any, which gave rise to immediate couse (o), stating the underlying couse last. 420.1
DUE TO
(c): caddiovascular disease — several yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from August 15, 1960, to August 15, 1961 that I last saw the deceased alive on August 11, 1961, and that death occurred at 9:30a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews, Jr. M.D. — ADDRESS (Street, city or town, state): 233 E. Main Street Elkton — DATE SIGNED: 9/15/61

PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/18/61

22c. NAME OF CEMETERY OR CREMATORY: Fair View Cemetery

22d. LOCATION (City, town, or county) (State): Thompson, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: PIPPIN FUNERAL HOME Donald H. Pippin Elkton, Md.

24a. REC'D BY REGISTRAR DATE: AUG 17 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registror prior to burial, cremotion, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9014 09006

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East (Rural)
c. LENGTH OF STAY IN 1b: ---
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Delaware
b. COUNTY: Newcastle ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington Rural
d. STREET ADDRESS: 4[illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Virginia	H	Davidson		August	25	19 61

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		Oct.20, 1920	40 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pvt. Secretary	Oil Ref.Catalytic Const.	Denton,Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Pennington Horsey	Grace May Hubbard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
	222-10-5960	Paul B.Horsey,Possum Point Rd.,Dunfries,Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Compound fracture of both legs and both arms, face and crushed chest	
DUE TO (b)	Car ran into abutment on Route 40 and Big North	None
DUE TO (c)	East Creek on east bound lane	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

8194

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
1:50 a.m. p.m.	19			North East	Cecil	Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): R.C. Dodson M.D. — R.C. Dodson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Aug 25,1961

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	8-28-61	Denton Cemetery	Denton Md.

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
J.Harvey Williamson Federalsburg,Md	AUG 28 '61	[signature]

1

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours [illegible] death. If an [illegible]ay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Page 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09007

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CECILTON
c. LENGTH OF STAY IN 1b: 10 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MIDDLETOWN R.D.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First GEORGE; Middle P; Last DAVIS

4. DATE OF DEATH: Month 8; Day 29; Year 19 61

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 6-23-1908

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Earl Davis

14. MOTHER'S MAIDEN NAME: Lilly Pierce

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Lilly Davis, Middletown R.D.2. Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: R.C. Dodson M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): R.C. Dodson

Address (City, town, or county): Rising Sun, Md.

DATE SIGNED: 8-29-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 2, 1961

22c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery

22d. LOCATION (City, town, or country) (State): Middletown Del.

23. FUNERAL DIRECTOR: Edward Gilbert ADDRESS: Millington Md.

24a. REC'D BY REGISTRAR DATE: SEP 5 '61

24b. REGISTRAR'S SIGNATURE: Carlton L. Kraus

Aorta Coronary Occlusion

Sarl Davis IAlly Pierce

Partner Partners Md. U.S.A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9016

CERTIFICATE OF DEATH

Reg. Dist. No. 09008

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NORTH EAST.
c. LENGTH OF STAY IN 1b: 2½ yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRATT NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
d. STREET ADDRESS: LANDING LANE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE — Middle MARY — Last DEIBERT

4. DATE OF DEATH: Month AUGUST — Day 31 — Year 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: DEC 27, 1870

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE B. DAVIS

14. MOTHER'S MAIDEN NAME: JULIA HITCHENS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: C. ELLIS DEIBERT — Address: ELKTON, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-Vascular Failure — INTERVAL BETWEEN ONSET AND DEATH: 15 MIN.
DUE TO (b): A.S.C.V.D Decompensated — Years
DUE TO (c): Chronic Glomerulo Nephritis c/Uremia — Years

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Cholecystitis & Chronic Rh. Arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-5-1959 to 8-31-1961, that I last saw the deceased alive on 8-30-1961, and that death occurred at 8.25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Luis Cuza M.D. — ADDRESS (Street, city or town, state): Cecil Ave. — DATE SIGNED:

PHYSICIAN'S NAME (Type): LUIS M. CUZA M.D. — NORTH EAST Md

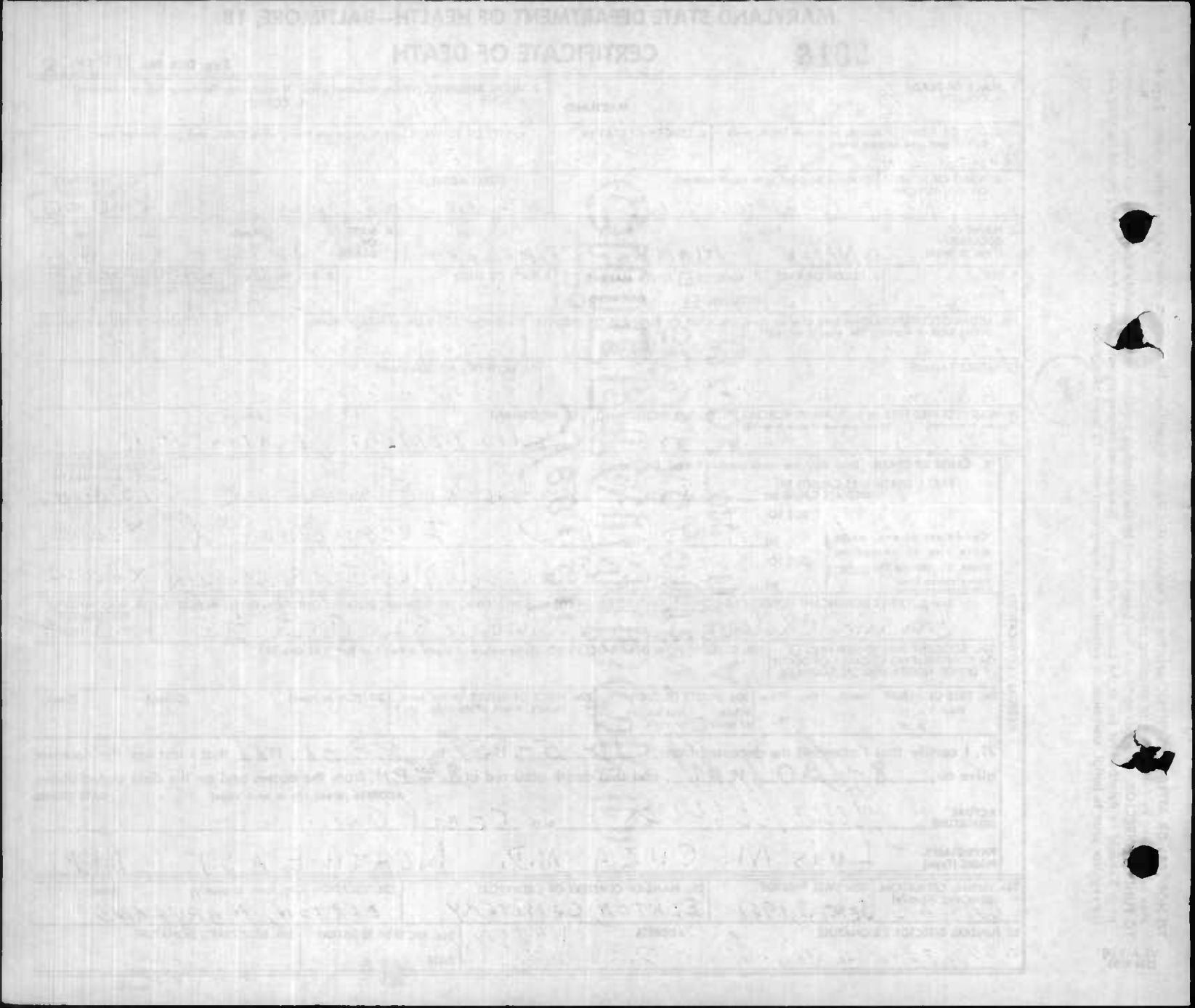
22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: SEPT. 3, 1961
22c. NAME OF CEMETERY OR CREMATORY: ELKTON CEMETERY
22d. LOCATION (City, town, or county) (State): ELKTON, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME — ADDRESS: ELKTON, Md

24a. REC'D BY REGISTRAR DATE: SEP 5 '61 SEP 5 '61
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9017 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05009

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Charlestown (Rural)
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): --

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: Berks
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oley Township
d. STREET ADDRESS: 75X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Horace	D	Dry	Aug.	14	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		July 21, 1887	74 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer	Farming	Hereford, Pa	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Hiriam Dry	Hettie Boyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No --	SS 180-20-3513	Mrs Deborah DeTurck, Oley Township, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: R.C.Dodson M.D. — DATE SIGNED

EXAMINER'S NAME (Type): R.C.Dodson, M.D. — Address (Street, city, town, or county): Rising Sun, Maryland — Aug.14,1961.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country)	(State)
Burial	Aug. 18, 1961	Frieden's Cemetery	Oley Township	Pa

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Joseph A. Grant north East Md Wallace Long Funeral Home, Oley, Pa.	AUG 16 '61	Arthur L. Kunis

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9018

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 32yrs.8mo.27days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 742 - 5th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle A. — Last DURST

4. DATE OF DEATH: Month August — Day 9 — Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3-4-74

9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Post Office

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James G. Durst (deceased)

14. MOTHER'S MAIDEN NAME: Anna Forrestelle (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): S.A.W.

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 1. Chronic Bronchitis. 2. Pulmonary Emphysema. 3. Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): generalized

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: VA 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I (this hospital)~~ attended the deceased from November 13 19 28 to August 9, 1961 ~~I (this hospital) last saw the deceased alive on~~ and that death occured at 11:10pm M. from the causes and on the date stated above.

22a. SIGNATURE: S. Goldgraben M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 8-10-61

22c. PHYSICIAN'S NAME (Type): S. GOLDGRABEN, Chief, Medical

22d. ADDRESS: Service, VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 11/61

23c. NAME OF CEMETERY OR CREMATORY: Balti more National

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Witzke Fun. Home, 4101 Edmondson Ave. Balto. Md.

25a. REC'D BY REGISTRAR DATE: AUG 14 61

25b. REGISTRAR'S SIGNATURE: Catherine L. Haines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Item 21 Film 293 8-24-61

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9019 — 09011

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 9/60

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b: 1 yr. 25 days

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 V01-4
d. STREET ADDRESS: 1907-W. North Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	LARRY	N.	ENGLISH		8	16	1961

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	NEGRO	NEVER MARRIED ☒	3-22-28	33 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mail Carrier	Post Office	Winston-Salem, N.C.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nathan Searcy	Lillian (?) English

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WW-II	219-28-6046	Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MANGLED BODY — INTERVAL BETWEEN ONSET AND DEATH: Immediate

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): STRUCK BY TRAIN

DUE TO (c):

E979X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour (Date)	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
6:15 p.m.	8-16 1961		Struck by train	Perryville	Cecil	Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — 8/16/61 DATE SIGNED

EXAMINER'S NAME (Type): R.C. DODSON, M.D. — Address (Street, city, town, or county): Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
BURIAL	Aug. 21, 1961	Baltimore National	Baltimore, Md.

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Charles R. Law, 802 Madison Ave. Balto. Md.	AUG 21 '61	Arthur L. Kraus

1

FOR STATE HEALTH DEPT.

M

050

I

IO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

IO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9020 — 09012

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 1 mo. 21 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salem
d. STREET ADDRESS: 126 Thompson 67x-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle (NMI) — Last FAHRNER

4. DATE OF DEATH: Month August — Day 10 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-25-95

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11. BIRTHPLACE (State or foreign country): France

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Fahrner

14. MOTHER'S MAIDEN NAME: Flora Shaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 1. Suffocation by drowning.
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

929.8

INTERVAL BETWEEN ONSET AND DEATH: Less than 10 minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
2. Cataracts, bilateral.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour 7: p.m. — Month, Day, Year 8 10 1961

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Susquehanna River

20f. (City or town) Perry Point, Md. (County) Cecil (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R.C. Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8/10/61

EXAMINER'S NAME (Type): R.C. DODSON

Address (Street, city, town, or county): Rising Sun, Md. (Cecil)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-14-61
22c. NAME OF CEMETERY OR CREMATORY: Presbyterian
22d. LOCATION (City, town, or country): Salem (State) N.J.

23. FUNERAL DIRECTOR — ADDRESS: Norman S. Newkirk, 54 Oak St. Salem, N.J.

24a. REC'D BY REGISTRAR — DATE: AUG 14 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9021 — 09013

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 2 mo. 9 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 12820 Holdridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15534-2

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
FLOYD	M.	HANNA	August	14	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		8-21-09	51 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Accounting Clerk	Dept. of Justice	Kansas	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas M. Hanna	Sarah Bryant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes — WW-II	579-12-0649	Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary edema & congestion, bilateral,	2-3 days
DUE TO	severe	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Adenocarcinoma of the rectum with metastasis	unknown
DUE TO (c)	to the liver	

154X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
	VA 19			

21. **I certify** that (I) (this hospital) attended the deceased from June 5, 1961 to August 14 1961 (last) saw the deceased alive on ~~xxxxxxxxxxxxxxx~~ 19~~xxx~~ and that death occured at 10:35 a.m. M, from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
A. L. Mooney			8-15-61

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
A. L. MOONEY Asst. Clinical	Pathologist, VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
REMOVAL	8/16/1961	Arlington National	Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE AUG 17 '61	25b. REGISTRAR'S SIGNATURE
Pennington-Hines, Havre de Grace, Md.			Arthur S. Kruse

(M)

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9022

CERTIFICATE OF DEATH

Reg. Dist. No. 09014

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 40 Years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Union Hospital, Elkton, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 214 East High, Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: L. — Last: Kane

4. DATE OF DEATH: Month: August — Day: 24, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/27/1891

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Queen Anne's, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Kane

14. MOTHER'S MAIDEN NAME: Priscilla Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-18-2315

INFORMANT: Mrs. Geraldine Kane — Address: 214 East High St. Elkton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Central Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1-Day
DUE TO
(b): Pulmonary Congestion — 1-Day
DUE TO
(c): Acute Nephritis and Acute Gastritis — 3-Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

590X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 22, 1961 to August 25, 1961, that I last saw the deceased alive on August 25, 1961 and that death occurred at 8 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James L Johnson M.D. — ADDRESS (Street, city or town, state): 245 East High Street — DATE SIGNED: 8/26/61

PHYSICIAN'S NAME (Type): James L. Johnson M. D. — Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/29/61
22c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cem.
22d. LOCATION (City, town, or county) (State): Bohemia Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John P. Bell — ADDRESS: 909 Poplar St.

24a. REC'D BY REGISTRAR DATE: AUG 30 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9023 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09015

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: 5 hours.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Pa
   b. COUNTY: Lancaster
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lancaster
   d. STREET ADDRESS: 953 East Orange
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: L — Last: LEMMON Lemon

4. DATE OF DEATH: Month: 8 — Day: 20 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-26-1876

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Laborer

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Lemon

14. MOTHER'S MAIDEN NAME: Emma Claud

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address Lancaster. Pa. — Mrs. Pricilla Lemon. 905 E. Orange St. L

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Insulin Shock. Hypoglycemia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: R.C.Dodson M.D. — DATE SIGNED: 8-20-61

EXAMINER'S NAME (Type): R.C.Dodson — Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 8/23/61 — 22c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn — 22d. LOCATION (City, town, or country) (State): Lancaster, Penna.

23. FUNERAL DIRECTOR: Pippin Funeral Home — ADDRESS: 25-9E. Main St Elkton, Md. — 24a. REC'D BY REGISTRAR DATE: AUG 24 '61 — 24b. REGISTRAR'S SIGNATURE: Arthur E. Krause

VS. A1SME SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9024 — 09016

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 36 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsburgh
d. STREET ADDRESS: 2256 Almont
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	FRED	(NMI)	LOEFFEL		August	18	1961

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	☐ / ☒ / ☐ / ☐	11-6-91	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver	Steel Corporation	Pennsylvania	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Alexander Loeffel	Rosina (?) Loeffel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes — WW-I	None	Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)	Pulmonary edema and congestion, severe	3-4 days
DUE TO (b)	Arteriosclerotic heart disease	unknown
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e): Arteriosclerosis generalized severe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	2Df. (City or town)	(County)	(State)
	VA 19					

21. **I certify** that ~~I (the hospital)~~ attended the deceased from August 29, 1925, to August 18, 1961 ~~I (we) last saw the deceased alive on 19~~ and that death occured at 5:15 am M, from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☐ / MED. DIRECTOR ☐ / STAFF PHYS. ☒	22b. DATE SIGNED
J. L. Garey			8-18-61

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
J. L. GAREY	Clinical Pathologist, V.A.Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
REMOVAL	8/19/1961	Zimmerman	Pittsburgh, Pa.

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Pennington & Son, Havre de Grace, Md.		AUG 22 61	Arthur S. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9025 — 09017

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bainbridge
c. LENGTH OF STAY IN 1b: 1 day 8½ hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): Station Hospital, USNTC

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Port Deposit
d. STREET ADDRESS: 234-Al Laffey Circle, Manor Heights
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard — Middle: Frank — Last: Manteufel, Jr.

4. DATE OF DEATH: Month: August — Day: 22 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 21, 1961

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days: 1 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): Cecil County, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Richard Frank Manteufel

14. MOTHER'S MAIDEN NAME: Masako (n) Soejima

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): ---
(If yes give were or dates of service): ---

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PREMATURE BIRTH, NEONATAL DEATH — INTERVAL BETWEEN ONSET AND DEATH: 32 hr. 30 min
776X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 21 1961 to August 22, 1961, that (I) (we) last saw the deceased alive on August 22 19 61, and that death occured at 5:00 PM, from the causes and on the date stated above.

22a. SIGNATURE: Gordon B. Avery M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 8-23-61

22c. PHYSICIAN'S NAME (Type): GORDON B. AVERY LT MC USN — 22d. ADDRESS: Station Hospital U.S. Naval Training Center, Bainbridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 8-24-61 — 23c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cemetery — 23d. LOCATION (City, town or county) (State): Colora Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson & Son — ADDRESS: LEE A. PATTERSON & SON, Perryville, Maryland

25a. REC'D BY REGISTRAR DATE: 8/23/61 — 25b. REGISTRAR'S SIGNATURE: AUG 24 '61 Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 M C 051 I 0 1 1961

205302 XVO

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9026

CERTIFICATE OF DEATH

09018

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 25yrs 26days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
03X-2
d. STREET ADDRESS: 9648 Alda Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALBERT Middle L. Last MAPUS
4. DATE OF DEATH: Month August Day 30, Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: October 20,1900
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker
10b. KIND OF BUSINESS OR INDUSTRY: Bakery
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN HENRY MAPUS
14. MOTHER'S MAIDEN NAME: ISABELLE CREAMER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): WW-1
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital Records, VAH., Perry Point,Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Rupture of Heart	2 to 5 Min.
DUE TO (b)	Due to Acute Myocardial infarction	4 to 6 days
DUE TO (c)	Coronary thrombosis	" "

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis Generalized

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from August 4, 1936, to August 30, 1961 that I (we) last saw the deceased alive on August 30, 1961, and that death occured at 2:35PM, from the causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8-31-61
22c. PHYSICIAN'S NAME (Type): A.L. MOONEY,M.D.,Asst.Clinical Pathologist,VAH.,Perry Point,Md.
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-2-61
23c. NAME OF CEMETERY OR CREMATORY: New Cathedral Baltimore National
23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Leman Ruck
ADDRESS: 5305 Harford Rd., Baltimore 14,Md.
RUCK FUNERAL HOME,
25a. REC'D BY REGISTRAR DATE SEP 5 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If there is delay, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9027 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 0301?

1. **PLACE OF DEATH**
e. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Charlestown
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wellwood Marina

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
e. STATE: Penna. — b. COUNTY: Delaware
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Haverford
d. STREET ADDRESS: 306 D Haverford Villa Apts.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75X-3

3. **NAME OF DECEASED** (Type or print): First HENRY — Middle FREDERICK — Last MARQUARDT

4. **DATE OF DEATH**: Month Aug. — Day 28, — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 15, 1905

9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales

10b. KIND OF BUSINESS OR INDUSTRY: School Supplies

11. BIRTHPLACE (State or foreign country): Elizabeth, N. J.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry F. Marquardt

14. MOTHER'S MAIDEN NAME: Elfrida No Information

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give were or dates of service)

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: Mrs. Eve Marquardt, Haverford, Penna.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: R. C. Dobson M.D.

EXAMINER'S NAME (Type): R. C. Dobson — Address (Street, city, town, or county): RISING SUN, Md.

DATE SIGNED: 8/28/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-31-61

22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

22d. LOCATION (City, town, or country) (State): Elizabeth, N. J.

23. FUNERAL DIRECTOR — ADDRESS: PIPPIN FUNERAL HOME — Donald M. Pippin Elkton, Md.

24a. REC'D BY REGISTRAR DATE: AUG 31 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5, 6, & 7 Film G293 8/18/61 mh

9028

CERTIFICATE OF DEATH

Reg. Dist. No. 09020

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PA. b. COUNTY: CHESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): WESTCHESTER
d. STREET ADDRESS: 7 S[illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ORVILLA Middle GRACE Last McCASLIN

4. DATE OF DEATH: Month AUGUST Day 10 Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 9, 1893

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE-WIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ISSAEHAR McCLAIN

14. MOTHER'S MAIDEN NAME: SARA PEOPLES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give wor or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Address: Mrs. Joseph Orr, Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO (b): Coronary Thrombosis — unknown

DUE TO (c): Atheromatosis, GAS — "

Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 9 Aug, 1961, to 10 Aug, 1961 that I last saw the deceased alive on 10 Aug, 1961, and that death accurred at 11 A.M. from the causes and an the date stated abave.

ACTUAL SIGNATURE: Robert W Ireland M.D. — ADDRESS (Street, city or town, state): P.O. Box 446 Rising Sun — DATE SIGNED: 10 Aug 61

PHYSICIAN'S NAME (Type): Robert W. Ireland MD Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/13/1961

22c. NAME OF CEMETERY OR CREMATORY: West Nottingham

22d. LOCATION (City, town, or county): Colora (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph M Reed — ADDRESS: Rising Sun, Md

24a. REC'D BY REGISTRAR DATE: AUG 14 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9029 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 113021

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton, R.4
d. STREET ADDRESS: R D 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cecil — Middle: Junior — Last: Osborne

4. DATE OF DEATH: Month: 8 — Day: 1 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9-14-1934

9. AGE (In years last birthday): 26 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: GENERAL

11. BIRTHPLACE (State or foreign country): N.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Stacey Osborn

14. MOTHER'S MAIDEN NAME: Laurie Eldrith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Fred Miller, Elkton, R.D.4. Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Drowned — INTERVAL BETWEEN ONSET AND DEATH

9.29.8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Walked into creek and sank

20c. TIME OF INJURY Hour a.m. 9.50 p.m. — Month, Day, Year: 8 1 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Elk Creek

20f. (City or town): Elkton — (County): Cecil — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R.C. Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): R.C. Dodson M.D.

Address (Street, City, town, or county): Rising Sun, Md.

DATE SIGNED: 8-1-61

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

22b. DATE THEREOF: 8/2/61

22c. NAME OF CEMETERY OR CREMATORY:

22d. LOCATION (City, town, or country): WEST JEFFERSON, N.C.

23. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME

ADDRESS: Dodd M. Dr. ELKTON, Md.

24a. REC'D BY REGISTRAR DATE: AUG 7 '61

24b. REGISTRAR'S SIGNATURE: Corinne S. Kinna

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9030

CERTIFICATE OF DEATH

09022

1. **PLACE OF DEATH** — a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
   c. LENGTH OF STAY IN 1b: 34yrs.8mo.20days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission) — a. STATE: District of Columbia — b. COUNTY: ✓
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
   d. STREET ADDRESS: 2813 Bellevue Terrace, N. W.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: FRANK — Middle: (NMI) — Last: PACH

4. **DATE OF DEATH**: Month: August — Day: 7 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-22-89

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Bakery

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Poch

14. MOTHER'S MAIDEN NAME: Pauline Auth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ventricular Arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: 10-15 min.

DUE TO (b): Arteriosclerotic heart disease — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis generalized severe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour e.m. / p.m. — Month, Day, Year: VA 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that ~~I (the hospital)~~ attended the deceased from November 18 1926, to August 7, 1961 ~~(we) last saw the deceased alive on~~ and that death occured at 6:30 am from the causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 8-7-61

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY — 22d. ADDRESS: Asst. Clinical Pathologist, VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 8-9-1961 — 23c. NAME OF CEMETERY OR CREMATORY: Arlington National — 23d. LOCATION (City, town or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawlers Sons — ADDRESS: Wash. D. C. — 25a. REC'D BY REGISTRAR DATE: AUG 9 '61 — 25b. REGISTRAR'S SIGNATURE: Caroline L. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9031

CERTIFICATE OF DEATH

09023

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Devine Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Delaware
b. COUNTY: New Castle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
d. STREET ADDRESS: 78 Kells Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Lola	Ellis	Phillips		8-22-61		19

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Nov. 10, 1879	81 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Delaware	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Ellis	Ann Virginia Phillips

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None	Claude E. Phillips	67 Kells Ave Newark, Dela.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	5 days
DUE TO (b)	arteriosclerosclerosis, cerebral	4 yrs
DUE TO (c)	Generalized arteriosclerosis	5 yrs

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2De. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from Mar 10, 1959 to Aug 22, 1961, that (I) (we) last saw the deceased alive on Aug 22 1961, and that death occured at 2:12 P.M. from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22b. DATE SIGNED
Wallace M Johnson M.D.	☒	☐	☐	8-22-61

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Wallace M. Johnson	257 E Main St Newark Del

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	8-25-61	Ralph's Hill Cemetery	Delmar, Delaware

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
William J. Warwick	Newark, Dela.	AUG 28 '61	Arthur L. Travis

WILLIAM J. WARWICK

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9032 09024

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Principio Furnace, Rural
c. LENGTH OF STAY IN 1b: 14 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Station Lane

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Principio Furnace, Rural
d. STREET ADDRESS: Station Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis; Middle: H.; Last: Smith

4. DATE OF DEATH: Month: Aug.; Day: 29; Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 5,1900

9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Day

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 217-03-3111.

17. INFORMANT: Jane Hammond, Principio Furnace, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
4 43X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Hypertensive Arteriosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 11, 19 60 to Aug. 29, 19 61, that (I) (we) last saw the deceased alive on Aug. 29, 19 61, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: George T. Stansbury, M.D.

22b. DATE SIGNED: 8/30/61

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): George T. Stansbury, M.D.

22d. ADDRESS: 569 Revolution Street, Havre de Grace, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept.1,1961

23c. NAME OF CEMETERY OR CREMATORY: Jones Memorial Cem.

23d. LOCATION (City, town or county) (State): Port Deposit, Md. Rural

24. FUNERAL DIRECTOR'S SIGNATURE: Lee a Patterson & Son,

ADDRESS: Perryville, Md

25e. REC'D BY REGISTRAR DATE: SEP 1 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9033

Reg. Dist. No. 19025

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton, R.D. 3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ralph — Middle: J. — Last: Speakman, Sr.

4. DATE OF DEATH: Month: August — Day: 17, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 9, 1895

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Thiokol Corp.

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joshua Speakman

14. MOTHER'S MAIDEN NAME: Carrie Shade

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Anna Chidester Speakman, Address R.D.3 Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-vascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
443X
DUE TO (b): Hypertensive cardiovascular disease — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 14, 19 61 to Aug. 17, 19 61, that I last saw the deceased alive on August 16, 19 61, and that death occurred at 2:45a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph Andrews Jr. M.D.
ADDRESS (Street, city or town, state): 233 E. Main Street Elkton Maryland
DATE SIGNED: 8/17/61
PHYSICIAN'S NAME (Type): S. RALPH ANDREWWS, JR., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/19/61
22c. NAME OF CEMETERY OR CREMATORY: Union Cemetery
22d. LOCATION (City, town, or county) (State): Union, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks
ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: AUG 25 '61
24b. REGISTRAR'S SIGNATURE: Clifton S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9034

CERTIFICATE OF DEATH

Reg. Dist. No. 09026

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~CLAYTON~~ CHESAPEAKE CITY
c. LENGTH OF STAY IN 1b: 45 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CHESAPEAKE CITY
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARIA — Middle PASLAWSKI — Last STATKAVIGE
4. DATE OF DEATH: Month AUGUST — Day 3 — Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 21, 1882
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): UKRAINE
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: No INFO
14. MOTHER'S MAIDEN NAME: No INFO
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
INFORMANT: MRS ESTELLE LUZETSKY — Address: CHESAPEAKE CITY Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 151X Gastric Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Carcinoma of Stomach — 6 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 10, 1931, to Aug 3, 1961 that I last saw the deceased alive on Aug 3, 1961, and that death occurred at 10:46 A.M. from the causes and on the date stated above.
ACTUAL SIGNATURE: Henry V. Davis M.D.
ADDRESS (Street, city or town, state): CHESAPEAKE CITY
DATE SIGNED: 8/9/61
PHYSICIAN'S NAME (Type): HENRY V. DAVIS MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/5/61
22c. NAME OF CEMETERY OR CREMATORY: ST. ROSES
22d. LOCATION (City, town, or county) (State): CHESAPEAKE CITY, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME
ADDRESS: ELKTON, Md.
24a. REC'D BY REGISTRAR — DATE: AUG 8, '61
24b. REGISTRAR'S SIGNATURE: William A. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9035

CERTIFICATE OF DEATH

09027

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 1 mo. 2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 4104 Gallatin 1662-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ALLEN; Middle: LAVERNE; Last: SUIT

4. DATE OF DEATH: Month: August; Day: 1; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 11-20-01

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Paper Hanger

10b. KIND OF BUSINESS OR INDUSTRY: Self-employed

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Everett M. Suit (deceased)

14. MOTHER'S MAIDEN NAME: Hannah E. Allen (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW-II

16. SOCIAL SECURITY NO.: 579-07-6021

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic anaplastic carcinoma (primary site undetermined) — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

199X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year: VA 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (did/did not) attended the deceased from June 30, 1961, to August 1, 1961 and that death occured at 7:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: B. S. Linn M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 8-2-61

22c. PHYSICIAN'S NAME (Type): B.S.LINN

22d. ADDRESS: Chief Resident, Surgical Service, VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 4-61

23c. NAME OF CEMETERY OR CREMATORY: Epiphany

23d. LOCATION (City, town or county) (State): Forrestville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros.

ADDRESS: Wash. D.C.

Simmons Bros. Fun. Home, 1661 Good Hope Rd. S.E.

25a. REC'D BY REGISTRAR DATE: AUG 4 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9036

CERTIFICATE OF DEATH

09028

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 9 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CONOWINGO RURAL
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HORACE Middle WILLARD Last TAYLOR

4. DATE OF DEATH: Month AUG. Day 23, Year 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/6/1886

9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER RET.

10b. KIND OF BUSINESS OR INDUSTRY: SELF EMPLOYED

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN TAYLOR

14. MOTHER'S MAIDEN NAME: FRANCES FLAHARTY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-01-6605

17. INFORMANT: RALPH TAYLOR Address: 14th ST. OCEAN CITY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Sigmoid Colon & Metastasis
153.3
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from June 16, 1961, to Aug 23, 1961, that (I) (we) last saw the deceased alive on Aug 22 1961 and that death occurred at 8:09 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Frank D. Hauber M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug 24, 1961.

22c. PHYSICIAN'S NAME (Type): Frank D. Hauber, M. D.

22d. ADDRESS: 601 South Union Ave., Havre De Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8/26/1961

23c. NAME OF CEMETERY OR CREMATORY: WEST NOTTINGHAM

23d. LOCATION (City, town, or county) (State): COLORA MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Vernon E. McMullen ADDRESS: RISING SUN, MD.

25a. REC'D BY REGISTRAR DATE: AUG 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur J. Kinsey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9037

CERTIFICATE OF DEATH

09029

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leeds
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leeds
d. STREET ADDRESS:
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): (SARAH) First: Sadie — Middle: Bell — Last: Thompson

4. DATE OF DEATH: Month: August — Day: 7, — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 3, 1871

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Companion

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John W. Thompson

14. MOTHER'S MAIDEN NAME: Sarah Ann Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 168-30-2210

17. INFORMANT Address: Mr. Elmer Jermyn, Elkton, Md. R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Anoxia	10 minutes
DUE TO (b)	Heart Block	15 minutes
DUE TO (c)	Arteriosclerotic Heart disease	years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 4/18, 19 61 to 7/7, 19 61, that (I) ~~(we)~~ last saw the deceased alive on 6/19 19 61, and that death occured at 9:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: J. Randall Ross M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): J. RANDALL ROSS, M.D.

22d. ADDRESS: Elkton MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/9/61

23c. NAME OF CEMETERY OR CREMATORY: Grove Cemetery

23d. LOCATION (City, town or county) (State): Grove, Pa.

24 FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hecks

ADDRESS: Elkton, Md.

25a. REC'D BY REGISTRAR DATE: AUG 14 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9038 09030

1 (M) 05 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
   c. LENGTH OF STAY IN 1b: 2 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: New York
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bronx
   d. STREET ADDRESS: 2706 Kingsbridge Terrace
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

69 X-3

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ELEANOR	(NMI)	THORNE	August	8	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		7-11-71	90 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Nurse	Private Duty	England	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Armstrong	Elizabeth (?)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WW-I	unknown	Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 5-10 Minutes — INTERVAL BETWEEN ONSET AND DEATH

420.0

DUE TO (b) Arteriosclerotic Heart Disease, Severe (Years)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerosis, Generalized (Years)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gangrene of left foot

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
	VA 19					

21. **I certify** that ~~I) (this hospital)~~ attended the deceased from August 14, 1959, to August 8, 1961 ~~that (I) (we) last saw the deceased alive on [illegible] 19[illegible]~~ and that death occured at 9:50 pm from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22b. DATE SIGNED
A. L. Mooney					

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
A. L. MOONEY	Asst. Clinical Pathologist, VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
REMOVAL	8/14/1961	Baltimore National	Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Leaming & Son, Harold Leaming	Md.	AUG 15 '61	Arthur L. Kraus

BP

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9039 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09031

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East Rural
c. LENGTH OF STAY IN 1b: few days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Nazerine Camp Grounds

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Pa.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ashland R.D.1
d. STREET ADDRESS: 75X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mabel; Middle: ; Last: Tietsworth
4. DATE OF DEATH: Month: 8; Day: 6; Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-12-1900
9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Michael Kessler
14. MOTHER'S MAIDEN NAME: Laura Slotterback
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no
16. SOCIAL SECURITY NO.: 200-22-8895
17. INFORMANT Address: Wilbur Tietsworth, Ashland, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R.C. Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): R.C. Dodson
Address (Street, city, town, or county): Rising Sun, Md.
DATE SIGNED: 8-6-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-10-1961
22c. NAME OF CEMETERY OR CREMATORY: Mabel U. B
22d. LOCATION (City, town, or country) (State): Mabel. Schuylkill Co. Pa

23. FUNERAL DIRECTOR ADDRESS: Joseph R Grant North East. Md
24a. REC'D BY REGISTRAR DATE: AUG 9 '61
24b. REGISTRAR'S SIGNATURE: Carlton L. Kirwan

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9040 — 09032

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East — Rural
d. STREET ADDRESS: Shadow Trailer Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ X

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Randall	D	Ward	Aug.	24	1961

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	NEVER MARRIED X	Aug. 30, 1957	3 yrs.	11	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	--	Grundy, Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lonzo T. Ward	Roaslie Fleming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
		Lonzo T. Ward, Shadow Trailer Park, North East

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis from ruptured intestine — INTERVAL BETWEEN ONSET AND DEATH: 8 days
DUE TO (b): Fracture of Pelvis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

835X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell off Milk Truck - (was moving)
20c. TIME OF INJURY: 10 AM a.m. / p.m. — Month, Day, Year: 8-16-61 — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Shadow Trailer Park
20f. (City or town): North East — (County): Cecil — (State): Md. (Rural)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Dallas Dodson, M.D.
Address (Street, city, town, or county):
DATE SIGNED: 8-25-61

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	8-27-61		Grundy Va.

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Joseph R. Grant / Joseph R. Grant, North East, Maryland	DATE AUG 28 '61	Arthur L. Kraus

Item 18 Film 293
8-16-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9041

CERTIFICATE OF DEATH

Reg. Dist. No. 09033

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Broad St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
d. STREET ADDRESS: Broad St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grace — Middle: S. — Last: Warner

4. DATE OF DEATH: Month: Aug. — Day: 8 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 17, 1889

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John W. Cochran

14. MOTHER'S MAIDEN NAME: Araminta Fray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Donald Cole Sr., Perryville, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerbro- Vascular Embolus — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
DUE TO (b): Post-operative joining of fractured — 5 weeks.
DUE TO (c): hip

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

903.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Pt. fell down coming out of church

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year: 7-2-61 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street - Church

20f. (City or town) Perryville (County) Cecil (State) Md.

21. I certify that I attended the deceased from 7-1, 19 61, to 8-8, 19 61, that I last saw the deceased alive on 8-3, 19 61, and that death occurred at 6:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lewis D. Hirsch M.D.
ADDRESS (Street, city or town, state): Havre De Grace, Md.
DATE SIGNED: 8-9-1961

PHYSICIAN'S NAME (Type): Gunther D. Hirsch M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-10-1961
22c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
22d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson & Son
ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: AUG 11 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1
FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9042 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09034

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE: N.J. b. COUNTY: Gloucester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural North East	c. LENGTH OF STAY IN 1b: 1 day
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glassboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Elk Neck State Park	d. STREET ADDRESS: 410 Franklin Rd 67X-3 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Dorothy	Nichols	Weir	August	6	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	white		August 3, 1943	18 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	-	New Jersey	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Gilbert S. Nichols Sr.	Elvena Van Note

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	149-34-7902	John W. Weir 410 Franklin Rd Glassboro N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carbon monoxide poisoning	
DUE TO (b)	charcoal stove burning in small closed tent	
DUE TO (c)		

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
?	8-6- 1961		State Park	Rural North East, Cecil, Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type): R.C. Dodson — Address (Street, city, town, or county): Rising Sun, Md

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	8-12-1961	Hill Crest Burial Park	East Pitman, Gloucester N. J.

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Joseph R. Grant North East, Maryland	AUG 14 '61	Arthur L. Kraus

1

FOR STATE HEALTH DEPT.

M

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9043

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09035

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural North East
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Elk Neck State Park

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: N. J.
b. COUNTY: Gloucester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glassboro
d. STREET ADDRESS: 410 Franklin Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

67X-3

3. NAME OF DECEASED (Type or print): First: John — Middle: Charles — Last: Weir

4. DATE OF DEATH: Month: 8 — Day: 6 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: March 4, 1941

9. AGE (In years last birthday): 20 yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator

10b. KIND OF BUSINESS OR INDUSTRY: Cloiser

11. BIRTHPLACE (State or foreign country): N.J.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John W.Weir

14. MOTHER'S MAIDEN NAME: Carolyn Minton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 142-32-2110

17. INFORMANT — Address: John W.Weir 410 Franklin Rd Glassboro N.J

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carbon monoxide poisoning — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): charcoal stove burning in small closed tent
DUE TO
(c):

X 90.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): State park

20f. (City or town) (County) (State): Rural North East, Cecil, Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: R.L.Dodson M.D.

EXAMINER'S NAME (Type): R.C.Dodson Rising Sun, Md

Address (Street, city, town, or county)

DATE SIGNED: August 9,1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-12-1961

22c. NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park

22d. LOCATION (City, town, or country) (State): East Pitman, Gloucester, NJ

23. FUNERAL DIRECTOR — ADDRESS: Joseph R Grant — Joseph R.Grant North East, Maryland

24a. REC'D BY REGISTRAR — DATE: AUG 14 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kinard

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9044

CERTIFICATE OF DEATH

09036

(M) (I) 550 46X-3

1. PLACE OF DEATH
a. COUNTY: Cecil MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 37yrs.11mo.12days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Delaware
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington
d. STREET ADDRESS: 1807 Green Lane, Arden
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: ROBERT Middle: F. Last: WHITESIDE

4. DATE OF DEATH Month: August Day: 22 Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-20-96
9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Leather Cutter
10b. KIND OF BUSINESS OR INDUSTRY: Wholesale Leather Establishment
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Not available
14. MOTHER'S MAIDEN NAME: Not available

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW-I
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Ventricular arrhythmia	10-15 min.
DUE TO (b)	Calcification of aortic valve	unknown
DUE TO (c)	Arteriosclerotic heart disease	unknown

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis generalized severe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year VA 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that xxxxxxxxxx attended the deceased from September 10 1923 to August 22 1961 xxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx and that death occured at 1:30 pm from the causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8-23-61
22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, Asst. Clinical Pathologist
22d. ADDRESS: VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) WH
23b. DATE THEREOF: 8/24/61 WH
23c. NAME OF CEMETERY OR CREMATORY: ~~Memorial Gardens~~ Druid Mount WH
23d. LOCATION (City, town or county) (State): ~~Arden, Wilmington, Delaware~~ Balto. Md. WH

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son ADDRESS: Pennington & Son, Havre de Grace, Md.
25a. REC'D BY LOCAL REGISTRAR DATE: AUG 28 61
25b. REGISTRAR'S SIGNATURE: [signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/60

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